

Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Viernes, May G. (ARCH)	CHAPTER 100.1
Address: 94-1184 Hina Street, Waipahu, Hawaii 96797	Inspection Date: November 17, 2020 Annual

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p><u>FINDINGS</u> Resident #1 – No telephone order for medication changes that were clarified with Physician by Primary Care Giver following resident's hospitalization from 3/13/20 thru 3/20/20.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	

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<input checked="" type="checkbox"/>	<p>§11-100.1-15 <u>Medications.</u> (h) All telephone and verbal orders for medication shall be recorded immediately on the physician's order sheet and written confirmation shall be obtained at the next physicians visit and not later than four months from the date of the verbal order for the medication.</p> <p><u>FINDINGS</u> Resident #1 – No telephone order for medication changes that were clarified with Physician by Primary Care Giver following resident's hospitalization from 3/13/20 thru 3/20/20.</p>	<p>PART 2</p> <p><u>FUTURE PLAN</u></p> <p>USE THIS SPACE TO EXPLAIN YOUR FUTURE PLAN: WHAT WILL YOU DO TO ENSURE THAT IT DOESN'T HAPPEN AGAIN?</p> <p><i>I have created a T.O. ✓ list and inserted it into my carehome binder and I will refer to it when taking T.O. in the future.</i></p>	<i>1/26/21</i>

Licensee's/Administrator's Signature: May G. Verner

Print Name: MAY G. VERNES

Date: 1/26/21